

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
DEPARTMENT OF PUBLIC HEALTH AND WELFARE

1379-63-008652
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

VS.300
Rev. 4/59

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USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DATE AMENDED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED FEB 19 1963 a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b.	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1529a N. 18th St.		d. STREET ADDRESS (If outside, give location) 1529a N 18th St.	
3. NAME OF DECEASED (Type or print) First PAULINE Middle GIERCZUK Last		4. DATE OF DEATH Month Feb. Day 7th , Year 1963	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6-22-1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Charwoman		10b. KIND OF BUSINESS OR INDUSTRY Mo. Pac. R.R.	
11. BIRTHPLACE (City and state or country) Poland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME John Zieniuk		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE Deceased.		15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or date) no none	
16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Bernice Orzel 2238a N. Market	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYPERTENSIVE and ARTERIOSCLEROTIC HEART DISEASE DUE TO (b) GEN. ARTERIOSCLEROSIS DUE TO (c) 443x PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 10 yrs - 15 yrs -	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION COUNTY STATE		21. I attended the deceased from 1958 to FEB 7, 1963 and last saw her alive on JAN 31, 1963 Death occurred at 8:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) John A. Carner, M.D.		22b. ADDRESS 4401 Hampton, St. Louis 9, Mo	
22c. DATE SIGNED 2-8-63		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE 11 FEB 63		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	
23d. LOCATION (City, town, or county) (State) St. Louis, Missouri.		24. FUNERAL DIRECTOR ADDRESS JOHN STYGAR & SON 5541 Riverview Bl	
25. DATE RECD. BY LOCAL REG. FEB 8 1963		26. REGISTRAR'S SIGNATURE Paul Smith, M.D.	

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

W. Fister

Licensed Embalmer No.

3980

P. O. Address

St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.